IPDR6702				NORTH CAROLINA		PA	GE: 1	
RUN DATE	: 02/05/2007		I	PRS CHECKWRITE SUMMARY REPORT CHECKWRITE DATE: 02/06/2007				
				FINANCIAL PAYER: NCDMH				
							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404901	SMOKY MOUNTAINM	21	3045	DUPLICATE OF CLAIM-SYSTEM				
	H/DD/SAS							
		8599	1025	DETAIL NOT COVERED BY COMBINAT	25	6389	6522	133
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
				BENEFII FACEAGE.				
		8505	486	CLAIM DENIED DUE TO INSUFFICIE				
				NT BUDGET				
3404904	WESTERN HIGHLAN	11	118	CLIENT NOT ELIGIBLE ON SERVICE DATE				
	DS LME			DATE				
		8654	9	ONLY 16 UNITS ALLOWED PER DAY WITHOUT PRIOR	(	129	1898	1769
				APPROVAL. PLEASE CORRECT THE				
		0505	2	CLAIM DENTED DUE TO THOUSENAME				
	+	8505	4	CLAIM DENIED DUE TO INSUFFICIE  NT BUDGET				-
3404910	ратима ус	11	397	CLIENT NOT ELIGIBLE ON SERVICE				
	PATHWAYS		1	DATE				1
		8599	117	DETAIL NOT COVERED BY COMBINAT	15	670	2612	1856
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8534	97	SERVICE FACILITY LOCATION IS N				
				OT A VALID IPRS ATTENDING				
				PROVIDER. PLEASE VERIFY THE F				
3404912	CATAWBA COUNTYM	8599	4	DETAIL NOT COVERED BY COMBINAT				
	ENTAL HEALT			ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
				Daniel I I I I I I I I I I I I I I I I I I I				
		8931	3	AMTNC INELIGIBLE TO RECEIVE SE	3	14	2990	2976
				RVICES IN IPRS.				
		10	3	DIAGNOSIS OR SERVICE INVALID F  OR CLIENT AGE. VERIFY CID,				
				DIAGNOSIS, PROCEDURE CODE FOR				
3404913	MECKLENBURG COM ENTAL HEALT	8599	2210	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND				
	ENIAL MEALI			BENEFIT PACKAGE.				
		3411	1579	PROVIDER TYPE AND SPECIALTY 07				
		2411	15/9	4/113 CANNOT BILL ENHANCED	121	4734	29543	24809
				BENEFIT SERVICES ON OR AFTER D				
		10	326	DIAGNOSIS OR SERVICE INVALID F				
				OR CLIENT AGE. VERIFY CID,				
				DIAGNOSIS, PROCEDURE CODE FOR				
3404916	CROSSROADS BEHA	8518	21	CLAIM DENIED, SUBMITTED BEYOND		1		-
	VIORAL HEAL			FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
		8532	18	SUBMITTED BILLING PROVIDER IS		79	4724	4645
				NOT ELIGIBLE FOR DATE OF				
				SERVICE BILLED				
		79	15	THIS SERVICE IS NOT PAYABLE TO				
				YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN				
								<u> </u>
3404917	CENTERPOINT HUM	11	291	CLIENT NOT ELIGIBLE ON SERVICE				
	AN SERVICES			DATE				
	1	8599	203	DETAIL NOT COVERED BY COMBINAT	3	697	6065	5368
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		8000	44	NO RATE AVAILABLE ON FILE TO P RICE THIS CLAIM DETAIL				1
							1	<u> </u>

DD OTTED DD		TIVAL PRIMARY					TOTAL	TOTAL
PROVIDER NUMBER		HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EUBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404919	GUILFORD CO MEN	8599	50	DETAIL NOT COVERED BY COMBINAT				-
	TAL HEALTHC			ION OF RECIPIENT, PROVIDER AND				
	TAL HEADING			BENEFIT PACKAGE.				<del> </del>
		3411	38	PROVIDER TYPE AND SPECIALTY 07	1	143	4428	4285
				4/113 CANNOT BILL ENHANCED				
				BENEFIT SERVICES ON OR AFTER D				
		11	19	CLIENT NOT ELIGIBLE ON SERVICE DATE				ļ
				DATE				
								-
3404920	AT AMANGE GACUET	8505	1306	CLAIM DENIED DUE TO INSUFFICIE				
	ALAMANCE CASWEL L AREA MH D			NT BUDGET				-
	D FACILITY FAIR D							
								1
		8599	101	DETAIL NOT COVERED BY COMBINAT	1	1567	3954	2387
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		21	81	DUPLICATE OF CLAIM-SYSTEM				ļ
	1		1		1			<del>                                     </del>
	1		1		+			<del>                                     </del>
3404921	ORANGE PERSON C	5312	1645	PRIOR AUTHORIZED DOLLARS EXCEE	+	-		+
	ORANGE PERSON C HATHAM AREA	-	1	DED DED	+			<del>                                     </del>
	million ration							
					1			
		8505	1327	CLAIM DENIED DUE TO INSUFFICIE	1	4416	8578	4162
				NT BUDGET				
		11	482	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE				
3404922	THE DURHAM CENT	21	295	DUPLICATE OF CLAIM-SYSTEM				-
	ER							-
	EK							
								1
		8952	128	CLAIM DENIED DUE TO AGE RESTRI	26	785	6688	5903
				CTIONS FOR TARGET POPULATION				
		8622	112	60 RESIDENTIAL LEVEL II TREATM				
				ENT RECEIVED, PA IS REQUIRED				ļ
				FOR ADDITIONAL SERVICE.				
3404923	DELIN GOLDWIN MIL	11	282	CLIENT NOT ELIGIBLE ON SERVICE				-
3101323	FIVE COUNTY MH		202	DATE				-
								-
		8536	47	ATTENDING PROVIDER TYPE AND SP	0	550	4806	4256
				ECIALTY COMBINATION IS NOT				
				VALID FOR SUBMITTED BILLING PR				
							-	
		3411	46	PROVIDER TYPE AND SPECIALTY 07				<u> </u>
	_		1	4/113 CANNOT BILL ENHANCED	1			↓
			1	BENEFIT SERVICES ON OR AFTER D	+			├
3404925	CAMBULAT C. COMMO	21	311	DUPLICATE OF CLAIM-SYSTEM	+			<del>                                     </del>
	SANDHILLS CENTE R FOR MH/DD				+			<del>                                     </del>
	A FOR PIN/DD		+		+			†
			+		1			†
		8599	297	DETAIL NOT COVERED BY COMBINAT	161	1475	13804	12329
				ION OF RECIPIENT, PROVIDER AND	202			1
				BENEFIT PACKAGE.				
		3412	140	PROVIDER TYPE AND SPECIALTY 07				
			1	4/113 CANNOT BILL ENHANCED	1			↓
	1		1	BENEFIT SERVICES ON OR AFTER D	1			₽
3404926		8518	203	CLAIM DENIED, SUBMITTED BEYOND	+			├
3404926	SOUTHEASTERN RE			FILING TIMELIMIT. PRIOR	+			<del> </del>
	G MENTAL HL		+	FISCAL YEAR DOS (JULY 1 - JUNE	+	-		+
	+		+		+			†
		23	127	SERVICE REQUIRES PRIOR APPROVA		811	10590	9779
	1		1	L	1	511	10390	2.73
					1			
					1			
		8599	116	DETAIL NOT COVERED BY COMBINAT				
			1	ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
	1	1	1	1	1	1	I	1

PROVIDER		HIGH DENIAL	NUMBER OF		mva	moma v	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	TNC	TOTAL	CLAIMS FINALIZED	CLAIMS
3404927	CUMBERLAND CO M	8950	45	CLIENT ONLY ENROLLED IN TRACKI NG POP GROUP. MUST ALSO BE				
	HC			ENROLLED IN A FUNDED POP GROUP		+	+	
		8599	44	DETAIL NOT COVERED BY COMBINAT	0	176	3054	2878
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.		-		
				BENEFII PACKAGE.		+		
		11	20	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE				
						-		-
3404930	JOHNSTON COUNTY	10	47	DIAGNOSIS OR SERVICE INVALID F				1
	MNTL HLTHC			OR CLIENT AGE. VERIFY CID,				
				DIAGNOSIS, PROCEDURE CODE FOR				
		8599	28	DETAIL NOT COVERED BY COMBINAT	_			
		0333	20	ION OF RECIPIENT, PROVIDER AND	0	124	4535	4411
				BENEFIT PACKAGE.				
		120	26	CLIENT ID NUMBER MISSING OR IN VALID. ENTER CID AND SUBMIT		-		-
				AS A NEW CLAIM				1
3404931	WAKE CO HUM SVC	8599	169	DETAIL NOT COVERED BY COMBINAT  ION OF RECIPIENT, PROVIDER AND	+	-	<del> </del>	-
	BILLING OF			BENEFIT PACKAGE.				
		11	45	CLIENT NOT ELIGIBLE ON SERVICE	11	398	12558	12160
				DATE		330		
		8621	31	60 RESIDENTIAL LEVEL III TREAT	+	-	<del> </del>	
				MENT RECEIVED, PA IS REQUIRED		1		1
				FOR ADDITIONAL SERVICE.				
2404022		0500	500					
3404933	SOUTHEASTERN CT R FOR MH/DD	8599	523	DETAIL NOT COVERED BY COMBINAT  ION OF RECIPIENT, PROVIDER AND		-		
	R FOR MH/DD			BENEFIT PACKAGE.		-		<b>+</b>
		8537	455	PROCEDURE IS NOT PAYABLE FOR Y	0	1759	10187	8428
				OUR PROVIDER TYPE AND SPECIALTY IN ACCORDANCE TO MEN				-
						-		<b>+</b>
		8329	193	CLAIM DENIED ATTENDING PROVIDE				
				R CANNOT BE THE SAME AS				
				THE LMA		-		-
3404934	ONSLOW CARTERET	8599	537	DETAIL NOT COVERED BY COMBINAT				1
	BEHAV HEAL			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8535	447	SERVICE FACILITY LOCATION WAS				
		0333	11/	NOT SUBMITTED ON THIS CLAIM.	0	1560	3962	2402
				PLEASE RESUBMIT THE CLAIM WITH				
		21	249	DUPLICATE OF CLAIM-SYSTEM		+		
								1
						<u> </u>		
3404935	WAYNE CO MENTAL	0	0	*** NO DATA TO REPORT ***		1		
	HEALTH CTR					<del> </del>		
						+	<del>                                     </del>	
		0	0		0	0	0	0
3404936	MATE COM COMPONENT :	191	6	CLIENT ID NUMBER DOES NOT MATC	1	<del> </del>	<del>                                     </del>	1
~101330	WILSON-GREENE M ENTAL HEALT	±9±	,	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME	-	+	+	1
	- TANK MERLI					<del>                                     </del>		<b>†</b>
		8534	3	SERVICE FACILITY LOCATION IS N OT A VALID IPRS ATTENDING	0	16	963	947
			1	OT A VALID IPRS ATTENDING PROVIDER. PLEASE VERIFY THE F		+	1	-
						1		1
		8599	3	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND		<del>                                     </del>	<u> </u>	1
		1	-	BENEFIT PACKAGE.	+	+	<del> </del>	-
3404937	EDGECOMBE NASH	21	20	DUPLICATE OF CLAIM-SYSTEM	<del> </del>	†	<del> </del>	<b> </b>
	MNTL HLTH C							
		-					ļ	
		8518	18	CLAIM DENIED, SUBMITTED BEYOND	0			1.00
		1		FILING TIMELIMIT. PRIOR	0	51	1672	1621
				FISCAL YEAR DOS (JULY 1 - JUNE		1		
		8599	13	DETAIL NOT COVERED BY COMBINAT		_		
		8599	13	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				

PROVIDER		HIGH DENIAL	NUMBER OF				TOTAL	TOTAL
NUMBER	DROUTDER NAME	EOBS	DENIALS	DESCRIPTION	TNC	TOTAL	CLAIMS	CLAIMS
	PROVIDER NAME				DENIALS	DENIALS	FINALIZED	PAID
3404939	NEUSE MENTAL HE	8599	32	DETAIL NOT COVERED BY COMBINAT				
	ALTH CENTER			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		0510	15	CLAIM DENIED, SUBMITTED BEYOND				
		8518	13	FILING TIMELIMIT. PRIOR		0 76	2087	201:
				FISCAL YEAR DOS (JULY 1 - JUNE				
		8654	8	ONLY 16 UNITS ALLOWED PER DAY				
				WITHOUT PRIOR				
				APPROVAL. PLEASE CORRECT THE				
3404941		27	125	DIAGNOSIS CODE MISSING OR INVA				
3101911	PITT CO MH/DD/S AS CENTER	27	123	LID. VERIFY AND ENTER THE				
	AS CENTER			CORRECT DIAGNOSIS CODE AND SUB				
		191	61	CLIENT ID NUMBER DOES NOT MATC		0 230	3650	342
				H PATIENT NAME				
		120	12	OF THE TO MINDED MEGGING OF THE				
		120	17	CLIENT ID NUMBER MISSING OR IN  VALID. ENTER CID AND SUBMIT				<del>                                     </del>
			+	AS A NEW CLAIM				
		_				1		<b> </b>
3404942	ROANOKE CHOWANH	10	9	DIAGNOSIS OR SERVICE INVALID F				
	UMAN SERVIC			OR CLIENT AGE. VERIFY CID,				
				DIAGNOSIS, PROCEDURE CODE FOR				
-								
		8654	7	ONLY 16 UNITS ALLOWED PER DAY WITHOUT PRIOR		0 34	368	33
		+	+	WITHOUT PRIOR  APPROVAL. PLEASE CORRECT THE		1		
				AFFROVAL. FIEASE CORRECT THE				
		11	5	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE				
3404943	ALBEMARLE MENTA	21	273	DUPLICATE OF CLAIM-SYSTEM				
	L HEALTH CE							
		1588	66	CLAIM DENIED. TREATMENT HAS B			25.45	200
		1300		EEN RENDERED BY	1	9 522	3547	302
				ANOTHER PROVIDER FOR THIS DATE				
		8599	52	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404944	EASTPOINTE HUMA	8599	54	DETAIL NOT COVERED BY COMBINAT  ION OF RECIPIENT, PROVIDER AND				
	N SERVICES			BENEFIT PACKAGE.				
				David II Inglands.				
		8935	20	ASTNC INELIGIBLE TO RECEIVE SE	3	7 150	6953	680
				RVICES IN IPRS.				
		8621	18	60 RESIDENTIAL LEVEL III TREAT				
		+	+	MENT RECEIVED, PA IS REQUIRED  FOR ADDITIONAL SERVICE.		1		
			+	TON ADDITIONAL SERVICE.				
3404946	FOOTHILLS AREAM	8505	518	CLAIM DENIED DUE TO INSUFFICIE		1		
	ENTAL HEALT			NT BUDGET				
						1		
		8537	208	PROCEDURE IS NOT PAYABLE FOR Y		0 1087	4613	352
				OUR PROVIDER TYPE AND	-			
				SPECIALTY IN ACCORDANCE TO MEN				
		8800	119	FURTHER PROCESSING NECESSARY,		1		
		0000	117	PLEASE CHECK FOR CLAIM ON		+		-
		_		FUTURE RA'S.		1		<b> </b>
		_	1			1		
3404957	TIDELAND MENTAL	8599	70	DETAIL NOT COVERED BY COMBINAT				
	HEALTH CTR			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8505	67	CLAIM DENIED DUE TO INSUFFICIE	4	2 203	1811	160
		+	+	NT BUDGET		1		
		_		+		1		
		8931	42	AMTNC INELIGIBLE TO RECEIVE SE				
		1	+	RVICES IN IPRS.				
		_	1			1		

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404979	NEW RIVER AREAM	8505	813	CLAIM DENIED DUE TO INSUFFICIE				
	H/DD/SA PRO			NT BUDGET				
		11	206	CLIENT NOT ELIGIBLE ON SERVICE	0	1086	1914	828
				DATE				
		167	30	NO CHARGE BILLED. ENTER BILLED				
				AMOUNT AND SUBMIT DETAIL AS				
				A NEW CLAIM				